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LME-MCO Communication Bulletin #J204

Date: June 6, 2016

To: LME-MCOs

From: Mabel McGlothlen, LME-MCO System Management Section Chief, DMH/DD/SAS and Kathy Nichols, Behavioral Health Manager, Community Based Services Section, DMA

Subject: Assertive Community Treatment Billing/Units

This bulletin clarifies billing requirements for Assertive Community Treatment (ACT). The Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) service definitions for ACT define a billing unit as a per diem.

As described in [Communication Bulletin # 137](#), August 20, 2013, the billing for this service is on a per diem basis. For a per diem rate to be generated, a 15 minute face-to-face contact that meets all requirements outlined in the ACT service definition must occur. Only one per diem may be billed per individual per day.

All other contacts, meetings, travel time, etc. are considered indirect costs and is accounted for in the build-up of the per diem rate. The appropriate number of contacts based on individual need. The reporting of ACT per diem visits applies to both Medicaid encounters and DMH/DD/SAS claims/shadow claims.

- DMA ACT service definitions:

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/8A-1_0.pdf

DMH/DD/SAS ACT service definitions: <http://www.ncdhhs.gov/document/state-funded-act-policy>

It is recognized that for a period of time, NCTracks had a four unit per month limit on the ACT units for payer DMH. This limit was removed over a year ago. However, in reviewing claims submissions, many LME/MCOs are currently submitting claims with 1-4 units per month, indicating a weekly event instead of a per diem. Also, the rates are set such that if more than 4 are billed, the total bill for the month exceeds the monthly approved

rate. Among claims submitted for payer DMH, there have been instances where the number units billed exceeded the default or approved LME/MCO-specific monthly amount.

Based on MEDICAID Healthcare Common Procedure Coding System (HCSPCS) Mental Health, Developmental Disabilities and Substance Abuse (MH/DD/SA) service rates, the default monthly rate for ACT is four times the listed event rate of \$292.35, which is \$1,181.28 per month (see https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/MHFees_070113.pdf).

Please be advised that:

- For DMH claims and shadow claims, the LME/MCO can only bill DMH for the amount paid to the provider, up to the default amount for the month (\$1,181.28), or DMH/DD/SAS approved LME/MCO specific rate.
- For DMA, the LME/MCO should submit encounters that reflect the amount paid to the provider.
- For both DMH and DMA, claims should be submitted to reflect all contacts that meet the requirements for per diem billing. Per diem reporting complies with National Correct Coding Initiative (NCCI) coding requirements, provides data for monitoring frequency of contacts, and assists with accurate performance reporting, such as timely follow-up after crisis and inpatient visits.

LME/MCOs have options on how they reimburse providers – providers do not have to be paid on a per diem basis, but they do need to report per diem contacts for submission to NCTracks. On 6/25/14 a workgroup of LME/MCO representatives and ACT providers recommended a monthly case rate with per diem shadow claims. If the LME/MCO chooses to use this model, it can be accomplished as follows:

Billing for Services Paid to Providers as a Monthly Case Rate

- The case rate may be billed on the first per diem contact of the month.
- Any additional per diem visits should be billed at \$0.01 per unit. LME/MCOs must identify these units to ensure the case rate is not reimbursed more than once per month. A modifier can be used in the LME/MCO's local billing system for this purpose, but does not need to be reported to NCTracks.
- For payer DMH, the LME/MCO is responsible for ensuring the default or approved monthly rate is not exceeded. The division will monitor for compliance.

Alternatively, if an LME/MCO chooses to pay providers on a per diem basis, the rate needs to take into account the number of visits may vary significantly based on individual needs, and the average payment per month for a provider should approximate the monthly amount of \$1,181.28. If this method is utilized, the authorized number of units should allow for instances when individual need exceeds the number of visits that would result in the average monthly amount. *For example, if the per diem rate is set at \$118.13, the rate assumes the average number of visits to be ten a month; the authorization would need to allow for more than ten visits a month, since some consumers would receive fewer visits.*

LME/MCOs may choose to incentivize providers to improve fidelity by paying a higher rate for higher scoring teams. For payer DMH, the LME/MCO can submit a provider-specific rate request. Rate approval is not required for Medicaid. LME/MCOs are encouraged to use the same rate and reimbursement method for both Medicaid and DMH funded consumers, for consistent billing practices and to ensure there is no cost-shifting between funders.

In summary:

- All per diem contacts must be reported as claims (DMH) or encounters (DMA).
- The LME/MCO may pay the provider a per diem rate or a case rate. When reporting to NCTracks:

- Bill a monthly case rate on one service event (i.e., day) per month and bill \$0.01 on all other service events.
 - For payer = DMH, the monthly case rate must not exceed the State rate of \$1,181.28 per month, unless LME/MCO requests a higher rate using the standard DMH/DD/SAS rate request process.
- Bill an appropriate daily rate if billing an equal amount for each day with a billable contact in the month.
 - For payer = DMH, if billing an equal amount for each unit (day), the LME/MCO should aim for an average monthly per person expenditure close to the default state rate or requested specific rate. The LME/MCO should specify their per diem rate using the standard DMH/DD/SAS rate request process.
- DMH expects that the total allowed value of claims adjudicated to PAID status in NCTracks will not exceed what the LME/MCO pays the ACTT provider.

If the LME/MCO is not currently meeting these requirements, they should begin doing so with billing submitted for July 1, 2016 dates of service forward. Please contact Stacy Smith at stacy.smith@dhhs.nc.gov or (919) 715-1294 with any questions about this communication.

Previous bulletins can be accessed at: <http://jtcommunicationbulletins.ncdhhs.gov/>

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